EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JAMES JIRAK and ROBERT PEDERSEN,	)	
Plaintiffs,	)	
vs.	)	No. 07 C 3626
ABBOTT LABORATORIES, INC.,	)	
Defendants.	)	

The deposition of MICHAEL RANCOURT, called for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before Lynn A. McCauley, CSR No. 84-003268, RPR, a Certified Shorthand Reporter of the State of Illinois, at 77 West Wacker Drive, Suite 3500, Chicago, Illinois, on August 26, 2009 at 9:02 a.m.

PRESENT:

JOSEPH & HERZFELD, LLP, by
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directly on -- you know, they wouldn't -- the physician would not have written it otherwise unless that rep convinced them of that script, not for every script, but for certainly the majority of scripts it's pretty -- it's well understood in our industry that the representative plays a very large part in determining -- in driving those sales by the way of convincing the customers to prescribe those products.

Q. Now, if I'm correct in primary care sales you have multiple reps calling on the same physicians; correct?

A. Yes. In most territories there are two to four representatives in a sort of team selling environment.

Q. Okay. So in those cases how do you know which rep is persuading the physician to write the script?

A. Yeah --

MS. OSE: Same objection.

THE WITNESS: Does this mean I still answer?

MS. OSE: (Indicating.)

BY THE WITNESS:

A. Okay. That's difficult to tell. It takes then the sales manager, right, that's why we

have district managers is that we measure the quantitative results from our sales results, from our sales reports, but we also have district managers who ride along with these representatives on a regular basis so they can put two and two together in terms of -- you know, based on the results, you know, if let's say one product is being sold by two different people on that team, those qualitative assessments that the manager makes in those ride-alongs can determine, you know, if Representative A is having a more pronounced effect on the results than Representative B.

So it is a combination. It very much is a combination of the quantitative results along with the qualitative assessment that a district manager does in coaching their representatives in the field.

BY MR. DI CHIARA:

Q. And a doctor can write a script for a Abbott product if that product has a favorable formulary position on a managed care plan; correct?

A. They can write it whether -- if it's an unfavorable as well.

Q. Okay. But formulary position on a

idea of DTC is that it appeals to patients directly offering a potential solution for a condition they may have, and it generates a discussion with a physician.

The physician, however, is still the ultimate decision maker.

BY MR. DI CHIARA:

Q. Does Abbott keep track, if you know, of prescriptions that are written but not filled?

MS. OSE: This is the same objection. Just to clarify, it's outside the scope of the 30(b)(6).

Mr. Rancourt can testify on his personal knowledge but not as representative of the company.

THE WITNESS: Can you repeat the question?

BY MR. DI CHIARA:

Q. Does Abbott have a way of tracking the number of prescriptions that are written but not filled?

A. No.

Q. Do all pharmacies report their prescribing information?

A. No.

Q. Which pharmacies don't to your knowledge?

be a credible source of information because physicians do rely on the information we provide to make those decisions.

And I've seen the same type of verbal, you know, coaching to other representatives when I've been a manager. You know, physicians reminding the representative that they play an important part in their decision making process.

Q. Does Abbott keep separate sales performance reports to reflect whether a prescription is written because of a rep's efforts or because of direct-to-consumer advertising or because of a favorable formulary position?

MS. OSE: Same objection.

BY THE WITNESS:

A. No, that's not possible.

BY MR. DI CHIARA:

Q. How long were you in the position of Area Sales Director for the Southeast Region?

A. One-and-a-half years.

Q. And what timeframe are we talking about?

A. It was January 2008 to June 2009.

Q. And were you employed by Abbott prior to June of 2008?

responsibilities as a Regional Manager for Primary Care.

A. Yes.

Primary responsibility was to increase the sales of the products that my sales team covered and had responsibility for in selling to their customers within that geography and those customers mainly being primary care physicians.

Q. And how would you go about increasing sales of your product?

A. From visiting customers on a daily -- my representatives would visit customers on a daily basis and discuss with them our products and ask for their verbal commitment to prescribe our products.

Q. Now, if a physician gave a commitment that they were going to prescribe an Abbott product, is that a binding commitment?

A. No.

Q. Anything else that you did to try to increase sales of your products when you were a Primary Care Regional Manager?

A. That was the primary mechanism by which we drove sales.

Secondarily, we also reviewed our

often travel to BI to sit in with them on meetings of stategizing how to market the product, working with our advertising agencies, working with in-house departments to pull together our sales materials.

But then on the Abbott side I would be responsible for connecting with our sales force and educating them on the product so that they were prepared to sell it in our sales force.

Q. Now, in a situation like you just described where Abbott is co-promoting a product with Boehringer Ingelheim, are there situations where there are Abbott reps and Boehringer Ingelheim reps in the same territory calling on the same physicians?

A. Yes.

Q. And in those situations can Abbott make a distinction as to what scripts are written because of the Abbott's rep's efforts or from the Boehringer's rep's efforts?

MS. OSE: Same objection as before. It is outside the scope of Mr. Rancourt's 30(b)(6) topics. He can testify on his personal knowledge.

BY THE WITNESS:

A. So from my knowledge it's a challenge, it's not a quantitatively precise mechanism, but it

goes back to what we talked about before around, you know, this is where the qualitative aspect of the district managers working with the representatives directly observing what they do and those DMs connecting with their DM peers from the other company, having those kind of discussions, help to diagnose who really are more effective than others to help remedy those situations and coach the representatives to be more effective.

So it was a combination of the qualitative and quantitative to help best determine the answer -- or the question that you asked.

Q. Would a Abbott district manager do ride-alongs with a Boehringer Ingelheim rep?

A. Occasionally. That was up to the local managers to decide.

Q. Okay. Before you became Product Manager, what was your position with Abbott?

A. Prior to Product Manager?

Q. Yes.

A. So prior to Product Manager, I was a District Sales Manager in New Jersey.

Q. Which part?

A. I was in Union County, and I covered the

we could just identify it by Bates number what the document is.

BY MR. DI CHIARA:

Q. Now, reps can't enter into contracts; right, with doctors?

A. You have to clarify which type of representative you're talking about.

Q. Primary care.

A. Primary care reps do not.

Q. What reps can enter into contracts if any?

A. Yeah, some do. There are certain specialty reps that do. Like I have not worked in this sales force, but like our Lupron sales force, it's a hormone. I think it's an injected product.

I've not personally worked with it, but I know historically that that's been a product that they've sold directly to physicians.

And then we have our managed care team that enters into contracts with managed care companies that involve rebates and such.

Q. Are reps part of the managed care team?

A. I'm sorry?

Q. Are pharmaceutical reps part of the

managed care team?

A. It's a separate sales force, managed care sales force.

Q. So other than that one category of reps that you said can enter into contracts with physicians, do you know of any pharmaceutical reps that can enter into contracts with physicians?

A. Not within Abbott's pharmaceutical products division.

Q. Again, we're just focusing on the pharmaceutical products. I just want to clarify.

Do the pharmaceutical reps that call on physicians have the ability to negotiate prices with physicians?

A. No.

Q. Do they have the ability --

A. Not the primary care representatives.

Q. Are there any other -- outside of the managed care sales force --

A. Well, again, I'm not an expert to speak on behalf of the Lupron sales force, so that would be -- I can't answer to that.

My knowledge of that sales force is that it is negligible, but I -- I'm really speaking

that a physician would tell a representative, you know, I want to write your product, but the local pharmacy tells me that they're out of it, so in that indirect way the representative circles back at the pharmacy to make sure the pharmacy orders it because they've been told the physician wants to use it.

So if that's an indirect way, it's not a direct order taking, but there is sort of that mechanism by which we do gain information from customers and relay that to the pharmacy to make sure that the order is placed if you will.

Does that make sense?

Q. Okay.

A. So it's indirect, not direct, but it's related to your question, so I wanted to clarify that.

Q. So a rep can walk into a pharmacy and say, you know, a doctor's telling me you don't have this product stocked. You need to order it?

A. Would you please order it. Request that, yes.

Q. Okay. And who would the pharmacy order the product through?

A. It depends on the pharmacy. You know,

certain chains, you know, would order through their chain distributor. Independents would order through their wholesaler.

Q. Do pharmaceutical reps get involved in, you know, taking orders or orders from pharmacies?

A. Let me think about this.

No, but we have another group called our national trade executives and that other separate sales force does get involved with the actual ordering of product to the -- through the distribution channel, from Abbott to the wholesaler to the distributors.

Q. And who negotiates the prices of Abbott products with wholesalers or pharmacies?

MS. OSE: Objection. This is outside the scope of Mr. Rancourt's 30(b)(6).

BY THE WITNESS:

A. Yeah, I haven't directly worked with those groups, but it's part of managed care and trade sales groups.

Q. Okay. Now, if a rep say leaves Abbott in January, will they be paid their bonus for the -- say they leave in January of 2010, will they be paid their bonus for the last quarter of 2009?

BY MR. DI CHIARA:

Q. Let's talk about the job duties and responsibilities for pharmaceutical reps.

What are they?

A. Well, in summary it's to visit their healthcare practitioner customers and present them information about our products and use convincing conversational skills to ask for their commitment to use our products instead of competitors.

Q. Anything else?

A. That is -- that's their mission.

Q. Okay. Now, is that -- those duties and responsibilities that you just described, is that the same for all pharmaceutical reps that you know of?

A. In that description that I just gave, yes.

Q. And that would be regardless of whether a rep's promoting products in New Jersey or Wisconsin?

A. Yes. Everybody knows this gig -- you're hired to hit your numbers.

Q. Okay.

A. How you go about that within each franchise there are different activities and such, but that description I gave you fits across the

part of the folks that we interface with.

Q. Understood.

Now, are reps allowed to have any contact with consumers about the Abbott products?

A. Not -- well, again, it depends on the franchise you're talking about like -- in primary care the representatives generally don't interface with customers or patients I should say, the end customer being the patient. HIPAA guidelines, you know, privacy protection forbids us to do that.

There are certain levels of indirect engagement with patients that take place in certain specialty sales forces like say HIV or immunology where representatives commonly sponsor patient advocacy programs where they would bring in a physician speaker and talk to the patients, and I'm sure that there's chitchat that occurs sometimes between patient and the rep just in the course of getting refreshments at those events, so in that type of context reps do sometimes interface with patients.

Q. Well, in the context of promoting the product reps don't call?

A. Correct.

Q. Won't call on the patients; correct?

A. Correct.

Q. Now, what would you say then is the rep's primary duty?

A. I thought I mentioned before that the rep's primary duty is to sell the products that they carry and use convincing logic to convince the physician to use more of the product, the Abbott product versus a competitor.

Q. And the customers, as you described them, that the reps call on that's given to the reps by Abbott; correct?

A. Yeah, we help them by giving them the data that we've purchased, right, of who the physicians are because this isn't like a cold calling business where anybody can use these products.

Q. Right.

A. You have to have a medical license, so we know who these physicians are, so we do provide them that list to make their job easier. It certainly saves them time from having to cold call, and we're able to give them data of those physicians who have a higher historical proscribing history.

Q. Is that called a call list?

A. Called different things, target lists,

call list, eventually -- you know one term you may be getting at is a call plan.

Q. Okay. And does Abbott require reps to call on doctors with a certain frequency?

A. It really depends. I mean each sales force operates with a call plan, so, in other words, at the beginning of a selling period the home office would send the representative a call list -- whatever you want to call it, a target list or a call list, it's a larger list -- and the representatives select which physicians they will select to be on their call plan which are the ones that they're committing to see regularly over that selling period, and they have an ability to add and drop physicians and, you know, make some changes within that call list.

Again, the master call list, whittling that down to the actual call plan, the rep plays a part in determining which ones end up on the final call plan.

Q. Okay. So the first call list that's given to a rep by Abbott, does that rank physicians as far as high prescribers, low prescribers?

A. Yeah.

Q. Now, does Abbott want the reps to focus

on the high prescribers?

A. Yes.

Q. So when a rep develops their call plan which is the whittling down of the call list --

A. Yeah.

Q. -- that call plan is going to have on it the high prescribers; correct?

A. Primarily, but there are other factors that go into the rep decision making process to decide who gets add and who gets dropped.

The rep's judgment is critical in this process because the home office only knows the quantitative history of those physicians.

The representatives would know the additional really critical qualitative info like who is accessible, who is and up-and-coming physician, right. They may have low history, but they're a young physician who is part of a busy practice and they're liable to be a high prescriber.

Those representatives have the ability to use their judgement to add those physicians. That's why we give them the add-drop process to use their judgment to affect that final call plan.

that call plan to help the rep make those judgment calls where they're adding and dropping.

Q. Now, so a rep can't -- well, can a rep go to the district manager after they get their initial call list and on their call plan have all either low or non-prescribers on it and say, here managers, these are the doctors I'm going to be calling on.

A. That would be very rare for that to happen. If a representative came to me with a list of all low prescribing physicians that they've added and they've dropped all these high prescribing physicians, I would have a very serious discussion with them about why they've done so because they're calling on lower producing customers in that case.

So typical a call plan would be a mix of some high prescribers which are pretty clear as to why they would be on there, and some low performers, low prescribers that would be based on the rep's judgment, but it should be probably more of like an 80/20, right, high to low. It shouldn't be this big list of low providers. I would really question a rep's judgement in that case.

Q. And would Abbott expect that a rep would call on the high prescribers more frequently than the

low or non-prescribers?

A. Yeah, and that just makes common sense that even a rep would want to call on those physicians more often.

MS. REPORTER: Can we take a two-minute break?

MR. DI CHIARA: Yeah, sure.

(WHEREUPON, a recess was had.)

BY MR. DI CHIARA:

Q. Now, you mentioned that the reps can add or delete physicians from the call list; is that correct?

A. Uh-huh, yeah.

Q. Okay. Now, can reps delete a physician from a call list for reasons other than the ones I'm about to list, either the physician died, retired, moved out of the territory, or is incarcerated?

A. Yes, they can.

Q. And what -- under what other circumstances?

A. Representative's judgment which would probably include access like they're inaccessible, or they're on the verge of retirement. I mean there are

just somebody who's a low writer who the representative deems is still important because of their reputation, you know, in the community.

That covers a pretty wide spectrum. I mean I'm not sure there would be any other reason why a rep would ever want to add another doc.

Q. Sure. And is there a limit as to how many doctors a rep can add?

A. Well, again, you acknowledged, and I verified, that there usually is a parameter of, you know, max adds, max drops that we set, and that add/drop sort of tool that is sent to reps to manage.

Q. So Abbott sets the parameters under which -- sets the parameters for the number of doctors that a rep can add or delete; is that correct?

A. Yeah. Keep in mind that each franchise operates a different call plan process.

Again, some use them, a lot of them use them, some don't; but every selling period the business rules that we call them for the add/drop process change based on what -- what's going on in the marketplace.

Q. But, again, does Abbott still --

non-prescribe?

A. Yeah, I mean that -- I would seriously call into question their judgment. I would want to learn more. I would use my coaching skills to learn more. Tell me more, Mike, about this call plan. This is very unique to see all these low prescribers. Tell me more about why you made those decisions.

Q. And what if the rep were to respond, Well, I think they're all up-and-comers?

A. I've never had that experience happen, and I don't think there's any legitimate case that in any territory in the country that would have that case where everybody would be -- should be added that's not on the default list.

Q. Okay.

A. It's just I've never seen that in my career. Let's just put it that way.

Q. Okay. So if I'm a rep, and you're a district manager, and I have all low or non-prescribers on my cal plan, and the district manager asks me, you know, Why do you have all these people on it? This doesn't make sense. And I say, Well, I think they're all up-and-comers. And you ask for an explanation. And I say, It's just a gut

feeling. Can a DM say, No, you need to change your call plan?

A. Absolutely. And they should.

In that case it's -- what your describing sounds like poor judgment that the representative is using.

Unless there's some absolutely out of -- off the wall, one in a million territory that this representative has that would call for that exception.

Q. Okay.

A. What you described would be highly unusual. I have to tell.

Q. Okay. Now, you mentioned that reps, that their job is to sell the Abbott product; is that correct?

A. Yes.

Q. How do they do that?

A. By visiting physician offices daily via either drop-in or appointment and getting one-on-one face time with that customer to engage in a discussion with them about their product use, their needs, you know, for patient treatment and how our product may fit those needs and ultimately asking for

their commitment to use our product.

Q. Now, we discussed this earlier, but the commitment to use -- if a doctor gives a commitment to use an Abbott product, it's a non-binding commitment; correct?

A. Absolutely.

Q. Now, what tools do reps use to sell their product?

A. They use sales materials, like what are commonly called sales aids and reprints.

Sales aids are the color brochures about the product, and the reprints are often, you know, the studies, clinical studies.

Q. Now, do reps, do they develop these sales aids?

A. No.

Q. Who creates the sales aids?

A. The marketing team, under the supervision of medical, regulatory and legal.

Q. Can a rep mark up a sales aid?

A. They -- can they, yes? Should they, no.

Q. Okay. Let me rephrase that.

Why shouldn't a rep mark up a sales aid?

A. Because the sales aid was approved because it met the approval of our medical regulatory department that says, yes, this fits within the label of the product.

By allowing a physician to mark up the sales aid, that -- that's really affecting the integrity of the material in that sales aid, and we wouldn't be able to control to what extent the rep would make changes that could be innocuous or actually equate material changes, so we have to have a policy of not making the changes to stay within label.

Q. Can reps make their own sales aids?

A. No. Well, can they, yes. Should they, no. It's against policy.

Q. Whose policy?

A. It's against company policy, and frankly the FDA would forbid that as well.

Q. Okay. Now, so if a rep creates their own sales aid and they think it's the greatest sale aid in the history of sales aids, they still can't use it on a sales pitch?

A. Correct. And I run across a lot of low performers that think that they know better how to

market a product and think they can develop a better one when really my experience tells me they can't.

Q. Okay. Fair enough.

So the people who are -- you know, the professionals who are responsible for developing the sales aids know what they're doing and --

A. Absolutely.

Q. Okay. Now, reprints, reps can only use approved reprints; correct, on sales calls?

A. Correct.

Q. Now, if a rep, say they're flipping through the New England Journal of Medicine, and they find this great study that supports the product they're promoting, but it hasn't yet been approved by Abbott, can they use that on the sales call?

A. No.

Q. Now, are reps allowed to -- can they highlight or mark up the reprints?

A. They can, but they should not.

Q. Okay. And for company policy reasons?

A. For the same company policy reasons. They -- if we allow that, who is to say they wouldn't block out certain things that would affect the integrity of that study.

Q. Okay. Now, are these -- well, who decides which reprints reps should use?

A. Our internal Medical and Regulatory Departments.

Q. Okay. Now, I've also seen some documents that reps get and say -- are you familiar with these -- that say, For representative use only. Not for detailing?

A. Yes.

Q. Can a rep use those documents, show them to a physician on a sales call?

A. Once again, can they, yes. Should they, no, because of what you just described, they're labeled, For representative education use only.

Q. So even if a rep thinks that this document they received that says, For representative use only, will help them, you know, increase market share, they shouldn't use it because it's against company policy?

A. Exactly. And I'm not aware of any material that truly could help a rep that you described. That's material that you describe in that way. That if they used it that it would help them more than if they just used their approved materials.

They shouldn't use those unapproved materials, and it wouldn't help them anyway, so I don't know why they'd want to.

Q. Okay. Because Abbott has people who develop those materials?

A. Absolutely.

Q. And now those rules concerning, you know, sales materials, sales aids and reprints, do those apply to all types of pharmaceutical reps at Abbott?

A. Yes. I mean each sales force is bound to operate within that sales force's approved materials. Of course, those materials differ by sales force, by product.

Q. Okay. Now, when a rep calls on a physician, can they say anything to a physician about the product that's not included in a sales aid, a reprint or some preapproved Abbott product?

A. Well, yeah, they can.

I mean all the dynamics of conversational language that go into a discussion aren't necessarily -- aren't going to be in a sales aid or a reprint.

But all the factual information about a product should come from an approved piece of

material, right, which is the sales aid or the reprint or the package insert.

Q. Yeah, and that's what I meant. I'm talking about like when a rep is talking to a physician about an Abbott product and describing the attributes of the product, they can -- they're limited to what -- as to what they can say based on what's in the product insert or a preapproved Abbott document; is that correct?

A. Yes, they're bound to reflect the attributes of the product that are printed in the package insert or our selling materials.

Q. Now, obviously if a doctor wants to talk about the Chicago Bears when a rep goes in, it makes sense for the rep to talk about the Chicago Bears and then try to segue into talking about the product?

A. I hope that they would.

Q. But, again, in a lot of instances when we were talking about the conversational aspect of the interaction between the rep and the physician, a lot of that is based on what the physician wants to talk about?

A. In many cases, yeah. I mean ideally the representative is hopefully setting a call objective

materials to all the reps -- well, I guess it's all relative, but I'm sure it costs a significant amount of money or -- let me withdraw the question because I -- for a pharmaceutical company I have no idea what a significant amount of money would be.

But in those sales -- in those training materials that's provided to reps where they provide probing questions, they're put there for a reason in the hopes that a rep will use them; correct?

A. Absolutely. To help train the representative on what a best practice might look like, right, from what other successful people have done and how they have sold the product in the past, we certainly want to create material, you know, written material at times that helps demonstrate to those representatives what good looks like.

Q. And reps are evaluated on their -- at least in part on their ability to ask probing questions to the physicians; correct?

A. Oh, jeez absolutely, yeah.

Q. Okay. Now, occasionally a doctor will have a question or an objection; correct?

A. Absolutely.

Q. Okay. And does Abbott provide reps with appropriate responses to certain types of objections?

A. We often do to make sure that -- you know, to give an example of how to stay within the label, right, so there are often common objections that we expect, either at the launch of a product or after the launch of a product, and we'll often tee those up in the form of a document to demonstrate to representatives again how to effectively use convincing sales language to answer that and hopefully address the physician's concerns, but most importantly to make sure that that is -- they are not speaking out of turn or making something up.

Q. So Abbott basically provides the reps with responses to particular types of objections?

A. To some objections, yeah.

Certainly not -- we certainly can't anticipate everything that comes up, so the ones that we think are going to be the most common we certainly try to educate the representative on what to expect and, you know, offer them suggestions on how they can address that.

Q. Okay. And reps are also evaluated on their ability to handle objections; correct?

time. Well, maybe OOS did better than that other product. Maybe that's what they're referring to here.

You know, what I mean? So the formulary change was sort of neutral because it affected our product equally to the way it affected the competitor, but yet our -- I'm reading into this -- but our product actually did well after that change.

Q. Okay.

A. But there's other information that I don't know that happens all the time. That doesn't necessarily mean that the formulary decision itself was the driving factor in the sales increasing.

Q. Okay. Now, in your experience in reading these evaluations over the course of your years, it seems that the district manager wrote in that it was put back on formulary.

A. I tell you why they put that in there.

Q. Okay.

A. Because it's important -- when a product does go on formulary, it's like now it's like sellable. Now it's like a product that customers can write, so you have to make sure that your

representatives are actively engaging in the right activity, calling on the right people, to make sure that because the customers can now write the product, that they actually do.

So the DM in this case is effectively recognizing that this was a selling opportunity that emerged during the year, right, and the representative did what they could to drive that chair as a result of that market occurrence.

Q. And the opportunity emerged because it was put back on formulary?

A. At least the opportunity for physician's to write the product seems to be the case.

But to what extent they could write that product and what their other choices were and how those changes may have simultaneously also occurred at that time, I don't know that from reading this.

Q. But you would agree that OOS being placed back on formulary did create a selling opportunity?

A. Yes.

Q. Okay.

A. Yep. That without representative action would be a latent influence.

A. Vaguely remember that. It's been a little while since Omnicef has been around.

Q. Sure.

Are reps also evaluated on their ability to deliver those types of messages to physicians?

A. Sure, yeah.

There's been market research tested with other physicians that has effective messages.

Q. Now, going back to the exhibit that's in front of you which I believe is Exhibit 2.

If you turn to Page 5 of the document, and you look at the Competencies -- you can take a minute just to look through these.

Are these the competencies that reps have been evaluated on since 2005 to the present? And you can look. I know there's a lot there.

MR. KNIGHT: Are you asking across all franchises?

MR. DI CHIARA: Yeah, I guess.

BY THE WITNESS:

A. Well, then the answer is no because in each franchise there are different -- there are different performance evaluations.

Q. Can you teach having a friendly personality?

A. No. That would be a talent.

Q. Okay.

A. But the art of like how to initiate conversations with like a nurse, with a receptionist, with a physician and how to do that differently to build a total office relationship, that's a skill that could be taught.

So if that makes sense, there are certain elements of this that are talents, but certain elements that are definitely teachable skills.

Q. And Abbott gives the reps examples of approaches that they can use with nurses and office managers and doctors in training; correct?

A. Certainly.

Yeah, because a lot of the folks we train, they haven't ever done this before, so getting a background on these customers -- these professionals they're going to interface with, we definitely give them some background. We often bring in physicians themselves into training to talk to the rep about how they like to be interfaced with.

Q. Going down to Business Judgment, what does that mean?

A. Well, it's being smart about where you spend your time, where you spend your resources, the decisions that you make because as a representative you have an unbelievable amount of autonomy and flexibility with how you spend your time and where you go without a boss looking over your shoulder. You're not in an office environment.

So it's important that we trust our representatives to use their heads, to use good decision making processes so that where they do spend their time, where they do spend their money, is with business judgment, they're using good judgment to make good -- to affect the business positively.

Q. So would it be good business judgment if a rep calls on high prescribers more frequently than low or non-prescribers?

A. Generally speaking, yes, but for a specific territory I would need to know more about that territory to know that dynamic, right, to be sure that in that case how you described it is the best judgment.

Q. Okay. And would also business judgment

be effectively using the sales pieces or detail aids that Abbott has provided for the reps?

A. I personally wouldn't consider that so much a business judgment piece as probably like selling effectively one of those.

I mean because, again, the description here, it's understanding the business, making good decision.

I see business judgment as more of like how you carry yourself overall. I don't see that as like exactly what tactics you use in every sales call. I mean it's all part of like a bigger picture.

But using the sales materials is more commonly used in a sales -- I should say a salesperson's performance evaluation. That would be more often reflecting in the selling effectively.

Q. Okay. Then you said it's more how you conduct yourself overall.

What does that mean?

A. Again, it's business judgment. It's making good decisions of where you spend your time. Like are you spending your time with, you know -- are you spending the whole morning on a low prescriber's

office, chitchatting with the nurse and not getting any commitments. That's a poor business judgment.

Are you walking into an office disheveled and not being a professional in how you carry yourself. That's using poor business judgment.

Spending money frivolously on a dinner program, allowing like a too-expensive bottle of wine being ordered, letting things get away from your control. That's a poor business judgement.

It's how you carry yourself in these business settings that's more of a overall sort of approach that you take. I look at that more in that way than I do in like did this person use this specific tactic or not. I look -- I would look at that as a separate competency.

Does that answer your question?

Q. I think so. And I have a few follow-up questions.

A. I mean business judgement is one of those things it's like you can describe it -- and hopefully I have -- but it's also one of these things that I think we can all agree on, it's one of those common sense sort of things that you know it when you see it, and you know it when you don't see it.

Q. Okay. So now I use the example you gave like where your spend your time, if you're spending your time with a low prescriber or non-prescriber, that would be in your mind poor use -- you gave a example of poor business judgment?

A. In this hypothetical example this territory was ripe with high prescribers that are accessible and yet this representative is spending their time with low prescribers just because they're accessible, that's poor business judgment.

Q. And Abbott would prefer that reps spend time with the high prescribers that are accessible?

A. I absolutely would prefer that they do. I would coach them heavily to do so yes.

Q. And then looking professional, as you said, that's common sense.

Now, as far as spending money frivolously, what do you mean by that?

A. Well, again, the representative has control of where they spend their money to do lunches, where they order from, who they invite.

Like, in other words, if you got an office of 50 people, well, that's a good office maybe to do pizza at lunch. Not, you know, $12-a-head, you

messages concerning compliance factors; correct?

A. Uh-huh.

Q. I'm sorry. You have to say yes?

A. Yes.

Q. Now, if I can direct your attention to I guess the document that has -- on the bottom right-hand corner you see Bates numbers that's 1111059?

A. Okay.

Q. If you look on the left-hand column, it might be hard to read, but the third row down it says, Discovery?

A. Uh-huh.

Q. What's Discovery?

A. A generic term for this would be Probe.

Q. Okay. Which is questions you ask the customer.

And here it looks like in this row that Abbott is providing reps with probes to use on their calls with physicians?

A. These are samples or examples, yep.

Q. And these are -- I'm assuming these are good examples or otherwise Abbott wouldn't put them in this training module; is that correct?

So there is a letter of the law, and there's a spirit of the law, and believe me when I tell you, when people say, I expect you to be in the field the whole day, it means, you know what, if you start late and end early some days because you've got to get your other stuff done, so be it. I just don't expect that every day you're going to not be out there until 10:00 or 11:00 or 12:00.

And I think that's the intention of why people would write something like that, expectations, because too many reps out there do work very few hours. They figured out how to game the system.

Q. Do reps -- do they supervise anyone?

A. Do the reps supervise any one, no.

Q. Are reps involved in developing any company-wide policies?

A. Not officially, no. I mean sometimes their ideas surface up to become part of policy.

Q. Is that part of their job description?

A. It's not part of their job description, no.

Q. Are reps involved in developing company-wide marketing strategy?

A. Well, yeah, not -- not as an official part of their job description, but they are often involved in what are called SMAC panels. It's another acronym we use, Sales Marketing Advisory Council.

Q. Right.

A. Where salespeople and marking folks are together in sort of a task force where marketing uses the rep input for future sales material development.

So the reps are involved, not as an official part of their job description, but they do get involved.

Q. Do they have any input into company-wide sales strategy?

A. I'm sorry. Was that a question you just asked?

Q. Yeah, do they have any involvement in the development of company-wide sales strategy?

A. Once again, it's like the marketing materials, not officially, but their input is very much taken into account in the context of these like SMAC panel advisory panel discussions.

Q. Well, how about -- how many reps sit on these -- what are these advisory panels?

A. It totally varies. Any rep who wants to be on them generally can be on them. It's one of these things where if reps want to get involved and be part of, you know, the larger team, with marketing and sales, then all they got to do usually is just ask their manager, Hey, is there SMAC panel that, you know -- an opening on one of these SMAC panels that I could be a part of.

I mean as a rep I was part of these all over -- all the time. I mean my whole career I've been on these different panels where sales reps and managers and marketing are all together and helping to develop the strategy jointly, so reps have an ability to be part of those discussions if they so choose.

Q. But it's on an advisory panel?

A. On an advisory panel basis, yeah. They have a full-time job to do which is to sell so that's not their full-time job.

Q. Whose full-time job is it to develop company-wide marketing strategy.

A. It's the marketing department's.

Q. And whose full-time job is it to develop company-wide sales strategy?

leading to written coaching, potentially leading to a performance improvement plan, which could lead to termination.

But it all starts with results, how is that person performing, and then you work down to what's driving that performance.

Q. And we'll get to that in a second.

Another question I wanted to ask is if a rep isn't calling on the doctors with the frequency that Abbott wants them to call on, could that also lead to disciplinary action or some sort of coaching discussion?

A. Absolutely. In the context -- the greater context of how is their overall performance?

Q. Okay.

A. It's a very narrow view for someone to coach or discipline strictly on activity. In a sales world you coach to -- first to results.

Q. Okay.

A. And behind that, you know, you diagnose, okay, the results are not going well. What's driving that?

Q. Now -- I'm assuming -- well, correct me if I'm wrong, but Abbott provides all these coaching

Q. It's not correct, or the reps don't develop those messages?

A. Well, the document you're looking at has suggested messages that do come from the home office, mainly marketing.

The representatives, though, it's common knowledge in this industry that the reps still rephrases the messaging to reflect the spirit of what was written in that document, but they're paraphrasing and rephrasing it to fit their own style.

Q. Understood.

A. And so in a sense they are messaging on their own, but the context of their messaging still fits within the spirit of what's on those printed documents.

They are guides. They're templates. They're not scripts. I mean there really is a distinction here.

Q. Okay. I didn't ask about scripts, but do -- at least the themes that you mentioned before, would you agree that reps don't develop those themes for the products?

A. That's true.

Q. And visual aids, they don't develop the visual aids; correct?

A. Correct, yeah.

Q. Okay.

A. I mean this wouldn't be unlike any product of service that any salesperson sells.

Q. I understand.

Now, as far as the bonuses that goes for reps, does a manager's subjective evaluation play a part in their -- the amount of their bonus?

MR. KNIGHT: Again 30(b)(6) testimony.

You can answer if you know.

BY THE WITNESS:

A. A rep's bonus -- the bonuses are a little different across the franchises, but in our primary care sales force that I work in now, 100 percent of the rep's bonus is based on the sales results.

MR. DI CHIARA: Okay. I think you can go.

MR. KNIGHT: I just have one thing I want to follow up on.

MR. DI CHIARA: Sure.

EXAMINATION

BY MR. KNIGHT:

Q. You had said earlier in the course of